Parents: Please complete this form to assist the school in meeting the specific needs of your child with diabetes. Please return to your school nurse by _____.

Primary Diabetes School Care Plan

Child's name_____ Date of birth_____

Grade_____ Teacher_____ School_____

Diabetes Medications (check ALL that apply):

☐ Humalog ☐ NPH ☐ Lente
☐ Novolog ☐ Lantus ☐ Ultralente
☐ Regular ☐ Other (specify) _____

Method of Insulin delivery during school hours:

☐ Syringe ☐ Insulin pen

Oral Diabetes Medications (please list): _____

_____

Blood Glucose Monitoring

Type of meter: _____ Time(s) of day to test: _____

Where is meter kept during school hours: _____

Location in school where student is to test: _____

Does child need assistance with blood glucose monitoring (please circle): Yes No

Recognition of Hypoglycemia (low blood glucose)

Symptoms typically seen:_____

Time of day most likely to occur:_____

At what blood glucose level should treatment be given:_____

Treatment of choice (provided by the family):_____

Recognition of Hyperglycemia (high blood glucose)

Symptoms typically seen:_____

Treatment: Liberal bathroom privileges and increase non-caloric fluid intake.

At what blood glucose level should parents be called? _____

Insulin correction dose: _____

Person responsible for administering insulin: ☐ Parent ☐ Child

☐ Other (list) _____

Additional instructions for Treatment:_____

If vomiting, call parents immediately.

School Lunch

Type of meal plan:

☐ **Carbohydrate Counting**

Some children may need to take an insulin injection prior to lunch. The insulin dose will need to be determined based on the grams of carbohydrate the child will be eating. Many children will have an insulin to carbohydrate ratio to help them match their insulin to food.

Insulin-carbohydrate ratio _____ unit(s) of insulin for every _____ grams of carbohydrate (example: 1 unit of insulin for every 15 grams of carbohydrate)

☐ **Set meal plan**

Some children will have a set meal plan where they eat the same amount of carbohydrate for each meal. A pre-lunch insulin injection is not necessary for children following a set meal plan unless they have a high blood glucose.

Snacks

Does child require snacks during school hours? (please circle) Yes No

If yes, at what times are snacks needed? _____

List food items to be provided by family for snacks. _____

Special Parties/Field Trips

Special parties, field trips & other events will occur during the school year. How would parents like to be contacted about these events? _____

Handling special occasions at school (please circle)

1. My child will be responsible for making his/her own choices. Yes No
2. I will provide appropriate substitutions for my child. Yes No

Other School Personnel

Please check which other school personnel should be aware of this Diabetes School Care Plan.

☐ Office staff ☐ Principal, Assistant Principal ☐ Lunch room personnel
☐ Librarian ☐ Teachers ☐ Classroom representative
☐ Bus drivers ☐ Substitute teachers ☐ Coaches / Advisors
☐ Other _____

Emergency Telephone Numbers

Parent/guardian name _____ Daytime Phone # _____

Work #_____ Home #_____ Cell # _____ Pager # _____

Parent/guardian name _____ Daytime Phone # _____

Work #_____ Home #_____ Cell # _____ Pager # _____

Alternate contact _____ Daytime Phone # _____

Work #_____ Home #_____ Cell # _____ Pager # _____

Alternate contact _____ Daytime Phone # _____

Work #_____ Home #_____ Cell # _____ Pager # _____

Parent/guardian signature_____Date_____

School nurse signature_____Date_____

Teacher signature_____ Date_____

Physician signature_____Date_____

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